FIRST HEALTH SYSTEMS

OCCUPATIONAL THERAPY EVALUATION AND TREATMENT PLAN

INSTRUCTIONS: This form must be completed by a licensed professional Occupational Therapist. Refer to the back side of the form for Objective Data Tests and Scales.

PERTINENT BACKGROUND INFORMATION

Facility _____

Resident _____ Room no. _____ Admission date ___/___/___ D.O.B. ___/___/___

Medicare no. _____ ☐ Part A ☐ Part B Other insurance _____

Treatment diagnosis _____ ICD-9 Code _____ Onset ___/___/___

MD referral and date _____ Date plan established ___/___/___

Prior level of function _____

Prior living situation/support system _____

Describe pertinent medical/social history and/or previous therapy provided _____

SENSORY/PERCEPTUAL MOTOR SKILLS

KEY: A-Absent I-Intact IM-Impaired U-Unable to test

Area	Sharp/Dull		Light/Firm Touch		Proprioception	
	RIGHT	LEFT	RIGHT	LEFT	RIGHT	LEFT
Distal UE						
Proximal UE						
Trunk						
Other						

VISION _____ VISUAL TRACKING _____

HEARING _____ R/L DISCRIMINATION _____

MOTOR PLANNING/PRAXIS _____

Do sensory/perceptual impairments affect safety? ☐ Yes ☐ No

If Yes; recommendations _____

STEREOGNOSIS: List items identified _____

Which hand did resident select? ☐ Right ☐ Left

MUSCLE STRENGTH/FUNCTIONAL ROM EVALUATION

Area	Strength		Action	ROM	
	RIGHT	LEFT		RIGHT	LEFT
Shoulder			Flex/Extend		
			Abd/Add		
			Int rot/Ext rot		
Elbow			Flex/Extend		
Forearm			Sup/Pron		
Wrist			Flex/Extend		
Fingers (Grip)			Flex/Extend		
Thumb			Abduction		
Cervical Spine			Flex/Extend		
			Rotation		

DESCRIPTION/MEASUREMENT OF PROBLEM: ☐ Arthritis _____

☐ Subluxation _____ ☐ Flaccidity _____

☐ Spasticity _____ ☐ Contractures _____

FUNCTIONAL INDEPENDENCE/BALANCE EVALUATION

	Task	Assist Score	Assistive Devices/Comments
BED MOBILITY	Roll/Turn		
	Sit/Supine		
	Scoot/Bridge		
TRANSFERS	Sit/Stand		
	Bed/Wheelchair		
	Toilet		
	Transfer Technique ☐ Appears functional ☐ Add'l training required		
BALANCE	Sitting/ Trunk control		
	Standing		

MOTOR COMPONENTS

FINE MOTOR COORDINATION: Right ☐ Intact ☐ Impaired

Left ☐ Intact ☐ Impaired

HAND STRENGTH: (Grasp) Right _____ lbs Left _____ lbs

PINCH: Type _____ Right _____ lbs Left _____ lbs

HAND LATERALITY: Right _____ Left _____

ORTHOTIC DEVICE REQUIRED? _____

TONE: _____

WHEELCHAIR SKILLS

☐ Maintains proper body alignment and support when positioned in wheelchair.

☐ Requires restraint in wheelchair.

☐ Propels self ☐ Needs assist

COMMENTS:

PSYCHOSOCIAL WELL-BEING STATUS

INITIATION OF ACTIVITY: ☐ Intact ☐ Impaired COPING SKILLS: ☐ Intact ☐ Impaired SELF CONTROL: ☐ Intact ☐ Impaired

Does resident recognize/acknowledge his/her physical limitations? ☐ Yes ☐ No

COMMENTS: _____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

☐ Continued on Reverse

OCCUPATIONAL THERAPY EVALUATION AND TREATMENT PLAN

SELF CARE SKILLS

Feeding:
Lip closure/drooling ☐ Intact ☐ Impaired
Tongue lateralization ☐ Intact ☐ Impaired
Ability to Swallow ☐ Intact ☐ Impaired
Ability to bring food/drink to mouth ☐ Intact ☐ Impaired
Use of utensils: _____

Grooming:
☐ Sitting / ☐ Standing for testing Comb hair _____ Shave _____ Oral Hygiene _____
Bed bathing _____ Sponge bath _____ Shower _____

Dressing:
Upper extremities _____ Lower extremities _____
UE/LE fasteners _____

Toileting:
Clothing management _____ ☐ Able to clean self
Maintain toileting position _____ on ☐ Bedpan ☐ Bedside commode ☐ Elevated toilet seat ☐ Standard toilet seat
Equipment recommendations _____

COGNITIVE STATUS

Alertness:
☐ Within functional limits ☐ Decreased ☐ Markedly decreased ☐ Unable to test
☐ Able to express needs Verbally ☐ Yes ☐ No Oriented to: ☐ Person ☐ Place ☐ Time
Safety awareness ☐ Intact ☐ Impaired Safety restraints present ☐ Yes ☐ No

Memory:
Short term memory ☐ Intact ☐ Impaired Long term memory ☐ Intact ☐ Impaired
☐ Able to follow 1 - 2 - 3 + step commands Length of attention span _____
Level of assist required to focus attention _____

Comments: _____ REHAB POTENTIAL _____

OCCUPATIONAL THERAPY TREATMENT PLAN

Short Term Goals	Time Frame	Long Term Goals	Time Frame	Treatment Plan
				Frequency & Duration:

Contraindications and/or precautions _____
Equipment recommendations _____ Discharge plan _____
Signature and title of Occupational Therapist _____ Date ___/___/___

OBJECTIVE DATA TESTS AND SCALES

MANUAL MUSCLE TEST (MMT) MUSCLE STRENGTH

GRADE	DESCRIPTION
5	Normal functional strength - against gravity - full resistance
4	Good strength - against gravity with some resistance
3	Fair strength - against gravity - no resistance - safety compromise
2	Poor strength - unable to move against gravity
1	Trace strength - slight muscle contraction - no motion
0	Zero - no active muscle contraction

FUNCTIONAL INDEPENDENCE SCALE (BED MOBILITY, W/C, BALANCE, GAIT)

GRADE	DESCRIPTION
5	Physically able and does independently
4	Verbal cue (VC) only needed
3	Stand-by assist (SBA) - 100% resident effort
2	Minimum assist (Min A) - 75% resident effort
1	Maximum assist (Max A) - 25%-50% resident effort
0	Totally dependent - total care

BALANCE SCALE (SITTING - STANDING)

GRADE	DESCRIPTION
5	Good balance responses bilaterally
3	Deficit balance but able to support self - at risk for falls
1	Poor balance - needs support

FUNCTIONAL RANGE OF MOTION (ROM) SCALE

GRADE	DESCRIPTION
5	100% active functional motion
4	75% active functional motion
3	50% active functional motion
2	25% active functional motion
1	Less than 25%

AVERAGE RANGES OF JOINT MOTION (ROM)

AREA	ACTION/MOVEMENT			
Shoulder	Flex	158°	Extend	55°
	Abd	170°	Add	50°
	Int rot	70°	Ext rot	90°
Elbow	Flex	145°	Ext	0°
Forearm	Sup	85°	Pron	70°
Wrist	Flex	73°	Ext	70°
Fingers	Flexall	90°	Ext	0°P
Thumb	Abduction 50%			
Cervical Spine	Flex	35°	Ext	35°
	Rotation 45°			

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed